SUPPLEMENT A

STATE OF RHODE ISLAND
PHARMACY PLUS WAIVER APPLICATION

UMMARY OF STATE-FUNDED PROGRAMS PARTIALLY SUBSUMED BY PHARMACY PLUS WAIVER

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idents with the high cost prescription medications necessary to treat chronic mental health conditions that otherwise would require institutional-level vices.

PAE is the Rhode Island Pharmacy Assistance Program for the Elderly, the state-funded program administered by the RI Department of Elderly Affairs th bsidizes the cost of prescription drug medications for Rhode Island seniors who do not have Rx coverage -- i.e., uninsured or exhausted benefit.

	RIPAE	GPA	CMAP
LIGIBILITY	Residents 65 and older	Incapacitated residents 19 to 64	Residents over age 18 w/chronic mental health conditions
Annual Income	@ 350% up to 420% FPL depending on family size	Under 100% FPL	No set income limit. Community Mental Health clinicians determine scope of need based on evaluation of drug costs and resources
★ Single	$37,167	$327 per mos.	
★ Couple	$42,476	$449 per mos.	
sset limits	Not Applicable	$400 per person	Not Applicable
n	Medical Expenses Up to 3% of Income	Not Applicable	Not Applicable
Citizenship	Citizenship does not affect eligibility	Not Applicable	Not Applicable
PPLICATION OCATIONS	★Senior Centers ★Community-based agencies ★ Senior outreach organizations	★DHS Offices	★Community Mental Health Centers
x BENEFIT	Limited Benefit – certain Rx medications are not covered	Limited Benefit – certain Rx medications are not covered	Only Medically Necessary Psychotropic Medications
OST-SHARING	Point-of-Service co-payments for covered Rx medications that vary by income from 40% to 85%. Full cost for non-covered	Not Applicable	None.

UMMARY OF STATE-FUNDED PROGRAMS PARTIALLY SUBSUMED BY PHARMACY PLUS WAIVER			
	medications.		
n = C=Married Couple	Level 1-40%: up to $16,619 (S) up to $21,149(MC)	Not Applicable	Not Applicable
	Level 2-70%: $16,920-21,238(S) $21,150-26,548(MC)		
	Level 3-85%: $21,239-37,167(S) $26,549-42,476(MC)		
NROLLMENT '02	34,000 w/average of 19,000 utilizing benefit per month	1,100	1,600
R	$11.9 million	$1,016,500	$3.6 million

supplementa.wpd--10/08

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

SUPPLEMENT B

STATE OF RHODE ISLAND
PHARMACY PLUS WAIVER APPLICATION

I. PROGRAM ELEMENTS

Income Adjustments – Health Insurance Premium Disregard: The $1,500 amount for the income disregard was selected as it is about 5% above the median annual premium costs for Medicare + Choice plans in the State. Out-of-pocket premiums for supplemental, and employer-based retirement plans in RI are generally somewhat lower. The State's goal in establishing the health care premium disregard is to both provide an incentive for enrollees to maintain alternative health coverage (i.e., a crowd-out measure) and to afford individuals who have high Rx costs, but income just over 200% of FPL, the opportunity to receive waiver benefits rather than spend-down to full Medicaid coverage using the flex-test.

Asset Limits: The State recognizes that asset limits are a valuable tool for ensuring that limited public resources are allocated to those with the greatest need. However, the State concluded that omitting an asset test will yield tangible benefits that far outweigh the attendant risks. In making this decision, the State considered, among other factors, the potential impact of an asset limit on: (1) scope and cost of providing coverage to particularly vulnerable segments of the target population; (2) recent experience with RIPAE, and (3) administrative ease and simplicity. Specifically:

- A significant percentage of RIPAE enrollees have income at or below 100% of FPL, but are ineligible for full Medicaid coverage due to assets. During any given year, a substantial number of individuals in this category become eligible for Medicaid as medically needy as result of high prescription drug costs. It is the State's hope that Rx coverage under the waiver will reduce their out-of-pocket health expenses, improve their health status and, in time, decrease the possibility they will spend down for full Medicaid benefits. As the State does not have reliable estimates of the waiver population's assets as a whole, it is not possible at this juncture to establish a targeted asset test that preserves eligibility for the individuals the **RIx +** program was intended to serve.

- RIPAE does not impose an asset limit. Although RIPAE offers coverage to individuals with income up to 420% FPL, less than 1/2 of the seniors eligible for the program are now enrolled (34,000 of an estimated 71,000). Moreover, of those who are enrolled, an average of about only one-third (13,500) used their RIPAE coverage during any given month in SFY 2002. The available data indicate that many of those who have opted not to either enroll in or utilize RIPAE Rx benefits have some other form of prescription coverage. Accordingly, the State does not expect this trend to change even though prescription coverage under the waiver will be less costly to enrollees and more expansive.

- Including an asset limit or test as a component of the waiver eligibility process has the potential to increase significantly both administrative costs and complexity. The State is committed to establishing a relatively simple application process based on one now in place for RIPAE. Also, the fiscal crisis now confronting the State has resulted in the across-the board cuts in administrative costs and personnel expenditures. As a consequence, the State does not have the staff resources necessary to implement a multi-tiered asset test capable of being targeted effectively and implemented with ease.

II. Benefit Management

Third Party Liability: Information regarding the availability of other third party insurance will be obtained through the

application process. TPL information will follow the same procedures that are now utilized for Medicaid beneficiaries.

Once TPL information is collected the insurer is contacted by the TPL Unit to verify policy number, effective date and coverage type. TPL information is also gathered via a series of tape matches with insurers. This information is posted into the MMIS. If there is a verified TPL segment for an individual, claims that fall within that segment are cost avoided. The provider is notified of the availability of other third party insurance and bills the other third party insurer. Once the other insurer processes the claim, the provider resubmits its claims to the Medicaid Program for wrap around coverage.

Pharmacy Benefit Management: The Department of Human Services has comprised a team of state staff, contractors and consultants to manage its pharmacy benefit program. Staff from DHS, Electronic Data Systems (EDS), Health Information Design (HID), and Heritage Information Systems contribute to manage the various tasks and functions necessary to insure high quality pharmacy services. EDS as the state's fiscal agent supports claim processing, provider relations and the Medicaid Management Information System functions. HID provides technical and professional support to the Drug Utilization Review Board. Heritage provides technical and professional support to the state's prior authorization process. The overall responsibility of managing the program resides within the DHS Center for Adult Health.

Prior Authorization: The State plans to use the prior authorization (PA) system now in place for Medicaid fee-for-service for the waiver population as well. The classes of drugs currently subject to prior authorization are disease-specific – i.e., targeted at particular illnesses or conditions like erectile dysfunction, obesity and attention deficit hyperactivity disorders for adults. Later this year, several additional therapeutic classes of drugs that will added to the prior authorization list, including Proton Pump Inhibitors and COX 2 NSAIDS.

The State Medicaid program will soon begin utilizing an electronic prior authorization system that was purchased on contract from a private firm. The system, called ***Smart PA***, in unique in several important ways. First, Smart PA provides point-of-service access to the medical criteria required to make prior authorization decisions through a pharmacy's PLS system. Once the pharmacist enters the Medicaid recipient's prescription into the PLS, Smart PA queries the State's MMIS to determine if the disease being treated, the patient's prior history, and other factors meet the conditions for approval. If PA criteria are met, Smart PA processes the claim for the Rx. If the PA criteria not met, or the information is missing the pharmacy will get a message to have the physician contact a call center for approval.

III. COORDINATION WITH OTHER COVERAGE

With the implementation of any new Medicaid eligibility expansion, there is always the possibility that a significant number of those in the target population will drop any alternative forms of private health care coverage they may have so they can take full advantage of the lower or no-cost publicly-funded program/benefit. When substitution of private coverage with public coverage occurs on a mass scale, it is know as the "crowd-out effect."

To reduce the potential for crowd-out, State policymakers have stated for the record that the **RIx +** pharmacy waiver coverage is to serve as a ***supplement to*** rather than as substitute for other forms of prescription drug and health care coverage. Specifically, R.I.L.G**.** 40-8-2.4, as amended by 2002 P.L., Ch. 65, Art. 24, directs the RI Department of Human Services to seek a Title XIX waiver to establish a pharmacy assistance program for State residents who are members of the target populations (age 65 and older; GPA and CMAP), have income 200% of FPL and below, and "***otherwise unable to pay the costs for medically necessary prescription drug medications***" (emphasis added*)*.

In deliberations prior to the enactment of the law, several Rhode Island policymakers indicated that, given the State's tenuous fiscal situation and federal budget neutrality requirements, it would not be possible to sustain the **RIx+** waiver program and maintain current eligibility levels for full Medicaid coverage if a crowd-out effect emerged. The impact that substitution could have on overall health status was also cited as an area of concern, particularly if pharmacy-only **RIx +**waiver coverage was used as a replacement for, instead of an adjunct to, more comprehensive health care benefits through Medicare + Choice or employer-sponsored retirement health plans.

In sum, in both the authorizing statute and the discussions that led to its enactment, State policymakers have made it clear that the purpose of the **RIx +** waiver program is to provide pharmacy assistance to members of the target population who are uninsured (i.e., no Rx coverage) or underinsured (i.e., limited Rx benefit that is insufficient to meet need). Although some level of substitution is in all likelihood unavoidable, the waiver proposal includes several features designed to limit the potential for a crowd-out effect. Rather than imposing eligibility restrictions like waiting periods that penalize individuals who drop other forms of coverage, the State has elected to utilize various incentives to maintain coverage including: a $1,500 income disregard for health insurance premium costs (see above); incentive payments, and wraparound coverage (see below).

Incentive Payment: During public meetings about the proposed waiver, members of the community expressed reservations about offering eligible low-income individuals the choice of a cash payment v. health benefit of considerably greater value. At issue is whether the financial hardships confronting many lower-income applicants will give them cause to opt for the $25 incentive payment rather than wraparound coverage, even in instances when their other Rx benefits were quite limited. RIPAE coverage would still be available for seniors in this group once their other Rx coverage was exhausted. However, there is concern that the program's narrower benefit and higher co-pays would provide them with insufficient relief in the event of catastrophic illness.

In response to these issues and concerns, the State elected to make the $25 incentive to maintain insurance available only to individuals with income above 150% FPL. The State's rationale is a follows:

- Studies which have examined similar issues in the human services policy arena have found that the propensity to choose cash payments over other forms of assistance decreases as income level increases from under 100% FPL until about 185% FPL and then levels-off.1 Members of the State's Medicaid Consumer Advisory Council (CAC) indicated that these findings are consistent with the experience of many the providers who work with seniors and persons with disabilities. Thus, individuals in the target population with income above 150% should be less likely than those with lower income to make decisions about coverage v. incentive payments on the basis of problems with cash flow.

- Census data, as well as information from RIPAE and other sources, suggest that members of the waiver target population with income above 150% are more likely than those with lower income to have Medicare + Choice or employer-sponsored retirement/group health plans that include comprehensive Rx coverage. As a consequence, the supplemental Rx coverage available through RIPAE should provide an adequate safety net for individuals in this group who opt for the $25 payment rather than wraparound coverage.

As an additional safeguard, the State plans to adopt a "good cause " policy that, in a narrow range of circumstances, will allow individuals who accept the incentive payment to request an exemption from the one-year bar on waiver enrollment. For example, the factors likely to be considered legitimate reasons for requesting an exemption include: the onset of a catastrophic illness and a significant change in either income or health insurance status due to a death or a divorce.

Wraparound Coverage: For the last two years, wraparound coverage has been utilized effectively in the State's RIte Share Premium Assistance Program both as an incentive to maintain private coverage and mechanism for ensuring comparability of benefits. The benefits now available through RIPAE for individuals who have exhausted private Rx coverage have been

1 See, for example: Tollen, L. **Purchasing Private Health Insurance through Government Healthcare Programs: A Guide for States.** (1999**:** Alpha Center).

delivered much like wraparound coverage and without contributing to substitution, or confounding enrollees unnecessarily, for nearly a decade. The State plans to build on its experience with these two programs when providing wraparound coverage to **RIx+** waiver enrollees with other forms of prescription drug coverage.

Waiver enrollees will receive a benefit card along with instructions explaining that they must present all Rx benefits cards to a pharmacist at the time a prescription is presented. Most seniors who are enrolled in RIPAE and/or health plans in addition to Medicare are familiar with this process. The State's Medicaid MMIS makes information available to the pharmacist indicating the scope of the waiver benefit and co-pay levels in much the same manner as do private insurers. Thus, the pharmacist will be able to determine at the point-of-service the Rx coverage available under the individual's private plan as well as the scope of wraparound coverage available under the waiver. State law requires pharmacists to explain to the enrollee, upon request, the manner in which various Rx benefits will be coordinated.

The RI Department of Elderly Affairs already has training materials and health insurance outreach specialists to assist seniors in the process of using multiple health benefit cards. The outreach specialists will also be able to provide information about the importance of maintaining alternative forms of health coverage, that provide more comprehensive benefits. The State hopes to make specialists available to CMAP and GPA recipients with other forms of coverage as well.

Over the next year, the State will be participating as a beta test site for an electronic prescribing program that will transmit Rx information from physicians to pharmacists using a secure, dedicated local area network. The ease in which wraparound coverage is administered will increase substantially once this system is in place and fully operational the next year.

Substitution by Insurers: The State recognizes that the success of its efforts to reduce the potential for substitution will be affected by trends in the commercial and Medicare + Choice market over which it can exercise little influence or control. Insurers in the State who serve the **RIx +** target population may modify the scope and cost of Rx coverage in the plans they offer, particularly to the elderly, to promote substitution (e.g. make other forms of coverage unaffordable by raising premiums, co-insurance, deductibles) and/or shift a greater share of the financial burden for Rx benefits to the State (e.g., increase State wraparound costs by through restricted formularies, setting lower benefit levels, increasing co-pays, etc.).

At this early point in the Pharmacy Plus Waiver Program, there is no data available about gaming in the commercial market from any of the states that have received approval for and begun implementation of their pharmacy waiver programs. ***As such, the State of Rhode Island would like to reserve the discretion to seek CMS approval for modifications in RIx + waiver program that will allow the State to respond effectively to changes in the commercial market that promote substitution.*** Such modifications may include the imposition of penalties (e.g., waiting periods) and other deterrents (e.g., annual deductibles similar to private plans) for substitution.

IV. COST-SHARING

In developing a cost-sharing strategy for the **RIx+** program, the State's principal objectives were as follows:

- Utilize a method of cost-sharing familiar to members of the target population that would not require costly modifications of existing information and financial systems;
- Set cost-sharing at or below the levels in place in RIPAE, CMAP and GPA and, to the extent feasible, maintain existing exemptions/exclusions included in these programs; and
- Promote the use of generic medications, encourage responsible utilization, and minimize costs.

To achieve these objectives, the State plans to use a point-of-service co-payment system for the **RIx+** waiver that is modeled on approach most common in the commercial market. The specifics of the system are outlined below.

Three-tiered Co-payments: Waiver enrollees subject to cost-sharing will be charged a flat fee for each prescription they fill at the point-of-service using a three-tiered co-payment system. As the chart below illustrates, the amount of the co-pay assigned to each tier varies depending on whether: (1) the medication is a name brand drug or generic substitute; and (2) the enrollee's annual utilization level is above or below $1,800 (State's share of cost excluding any enrollee co-pays).

RIx+ Co-payment Schedule			
	Tier 1 Generic	**Tier 2 No Generic**	**Tier 3 Name Brand**
Level 1- Below $1,800	$2	$10	$20
Level 2 $1,800 & up	$4	$12	$25

In keeping with the State's cost-sharing objectives, the co-payment rate for tier 1 medications has been set significantly lower than the rates for the other tiers 2 and 3 to encourage enrollees to fill prescriptions with generic drugs whenever available. As the State recognizes that there will be circumstances in which there is not a generic substitute for a particular medication, the tier 2 co-payment has been set lower than the rate for tier 3 so as not to penalize enrollees, but above the rate for tier 1 to reflect the higher cost of brand name drugs to the State.

The amount of the co-payment rate for each tier has been set to ensure that the cost-sharing obligations of the target population at present will not increase once they become enrolled in **RIx+** waiver. Seniors enrolled in RIPAE who would qualify for **RIx+** now pay 40% of the State's cost for every prescription filled. The waiver's three-tiered co-payment structure will reduce this amount to 13%, on average at Level 1, and about 35% once annual utilization reaches Level 2.2 As is current practice in the State-funded program, CMAP participants who are enrolled in the waiver will not be required to pay a share of the cost for psychotropic medications. For all other prescriptions filled, however, CMAP-eligible enrollees will be subject to the **RIx+** co-payment schedule. GPA recipients will not be subject to cost-sharing unless utilization rates rise well-above projected levels. As indicated earlier, it has long been State policy to exempt from cost-sharing any individuals who qualify or receive cash assistance.

Although this multi-tiered and layer cost-sharing system may seem inordinately complex, the State is confident that the systems now in place, and under-development, for Medicaid recipients will ensure **RIx+** enrollees will have ready access to seamless prescription coverage. Moreover, the RI Departments of Human Services and Elderly Affairs plan to offer enrollees information and training on the scope and use of **RIx+** benefits prior to implementation as of the date the waiver request is approved.

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2 This figure is based on an analysis of recent prescription medication utilization patterns of Medicaid recipients 65 and older and the RIPAE population by tier co-payment levels. The State expects waiver enrollees Rx patterns to include a similar mix of generic and name brand medications given the incentives to use generic medications.

Utilization Levels: The State established two levels of co-payments for the **RIx+** part of the broader effort to both promote responsible utilization of prescription medications and contain costs. The $1,800 demarcation between Level 1 and Level 2 co-payments was selected after examining at length the Rx utilization patterns of Medicaid recipients with characteristics similar to the target population. Currently, average State costs for Medicaid Rx coverage in this group is about $1,500 per recipient, per annum. After factoring in adjustments for inflation and the higher cost of medications for the CMAP and the chronically ill, the State determined that the average annual cost for providing coverage to each waiver enrollee, excluding co-payments, should be about $1,800.3

Given current Medicaid trends, the State does not anticipate that a significant number of enrollees will incur more than the estimated $1,800 annual average benefit. Accordingly, rather than cap the benefit once Rx costs reached this level, the State has opted to increase the amount of co-payments in each tier by a small amount. In choosing this strategy, waiver coverage for enrollees with high chronic illnesses and conditions will be preserved.

3 This figure has not been reduced to reflect drug rebates or projected savings from prior authorization, coordination with other forms of coverage and benefits management.

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

STATE OF RHODE ISLAND
SUPPLEMENT C

STATE CONTEXT

I. Overview of Rhode Island Medicaid

Nearly one-third of Rhode Island's population of just over one million is age and income eligible for Medicaid benefits of one kind or another.[1] Although only about one-half of the eligible population regularly participate in Medicaid (about 167,000 recipients of a possible 337,000 in 2001), the program's expansive reach is one of the chief reasons the State's uninsured rate has been among the lowest in the nation for the last two years.[2] The benefits provided to RI Medicaid recipients are also quite broad; by some estimates, the State Medicaid program's benefit package is among the most comprehensive in the nation.[3] Given the scope of the program, it is no surprise that Medicaid is by far the State's largest budget item. In State Fiscal Year (SFY) 2003, Medicaid expenditures are projected to be about $1.6 billion, slightly less than 50% of total State spending for the year.

The greatest growth in RI Medicaid over the last five years has been the result of eligibility expansions in programs on the children and family side.[4] There have also been several increases in the scope of eligibility for the aged and persons with disabilities since 1997.[5] However, the number of recipients in this category has remained constant (51,000 in 1997 and 51,000 in 2001) and, as such, has declined as a percentage of the total Medicaid population in the last five years (51,000 of 124,000 or 41% in 1997 v. 51,000 of 167,000 or 30% in 2001).[6] Yet, in spite of its comparatively small size, the population of aged and disabled Medicaid recipients is responsible for two-thirds of the program's annual costs. For example, in 2001, benefits and services provided to the 51,000 Medicaid recipients who were eligible due to advanced age (i.e., age 65 or older) or disability (i.e., living with a chronic and disabling condition) accounted for 64% of total program expenditures ($735,000,000 of about $1.2 billion). Though expenditures for persons with disabilities were somewhat higher than those for the aged (53% v. 47%, respectively), institutional-level care (i.e., hospitals, nursing homes, and home and community-based services) accounted for about 83% of the total cost of services provided to members of both groups.[7]

II. RIx+ Target Population: Characteristics, Utilization and Coverage Trends

Despite the breadth of the Rhode Island Medicaid program, rising costs, particularly for Rx drugs, have reduced access to health care for some of the State's most vulnerable residents. Among those most at risk are low-income Medicare beneficiaries who, although living on the margins of poverty, do not qualify for Medicaid benefits due to excess assets and/or income. As the chart below indicates, seniors in this group are by far the largest segment of the proposed **RIx +** pharmacy waiver target population.

RIX + TARGET POPULATION: MEDICARE BENEFICIARIES TOTAL RI MEDICARE BENEFICIARIES[8] DECEMBER 2001=171,500	
Income Qualified for RIx + (200% FPL or below)	83,000 (48%)
• **Aged**	75,530 (91%)
• **Disabled**	7,470 (9%)
Medicaid Eligible	43,300 (52%)

(SSI, Dual Eligible, Categorically Needy)	
Total Aged and Disabled Potentially Eligible for Waiver	39,700 (48%)
• **Total Aged Eligible for Waiver -**	34,000 (86%)
• **Total Disabled Eligible for Waiver –** Estimated 1/3 of CMAP population	627 or 11% of 5,560 Total Potentially Eligible Disabled
Total Medicare Beneficiaries Eligible for Waiver as Percent of Target Population of 37,000	**34,637 94%**

As Medicare does not provide a pharmacy benefit for seniors living in the community, the escalating cost of prescriptions has not only strained the resources of most members of the target population, but of the State-funded programs and private health insurers they look to for assistance as well.

Until the late 1990s, the State's pharmacy assistance programs (i.e., RIPAE, CMAP and GPA) provided an adequate measure of prescription coverage to most low-income residents ineligible for Medicaid. However, in the last several years, it has become increasingly more apparent that these programs are too limited in scope to meet the growing demand for high cost prescription medications. For example, in RIPAE, both the number of enrollees and their Rx utilization rates have increased only marginally since 1999; by contrast, total expenditures per enrollee have risen sharply during the same period, by upwards of 51% per annum on average.

Medicare + Choice, Medi-gap and employer-based health plans that offer various levels of pharmacy coverage are declining in number and increasing in cost, even though still available to many Medicare beneficiaries in Rhode Island.[9] According to one account, in 2001, an estimated 85% of the State's 171,500 Medicare beneficiaries had one form or another of private supplemental or alternative health coverage:

- Thirty-three percent (56,600) were enrolled in a Medicare HMO;
- Twenty-one percent (36,000), had a privately or employer purchased Medi-gap plans; and
- Thirty-one percent, (53,165) were covered through an employer-based retiree health plan.[10]

About 40% of those enrolled in these plans were reportedly provided with a pharmacy benefit – i.e., 50% of Medicare + Choice and employer-based retiree plan enrollees, and 20% Medi-gap enrollees. By contrast, in 1996, 90% of the State's Medicare beneficiaries had alternate health coverage (over half through retiree plans) with more than two-thirds enrolled in plans that included a pharmacy benefit.

Declining enrollment in alternative and supplement health plans is due, at least in part, to the fact that there are fewer employers and insurers offering seniors and retirees health benefits today than in the past. There is evidence that the increasing cost of coverage has also played an important role, however. For example, average annual out-of-pocket costs for health plans including Rx benefits have climbed steadily over the last few years. By one account, out-of-pocket expenses for prescription medication coinsurance and deductibles alone have doubled in the last three years to an estimated average of $860 per annum, excluding premiums; this figure is about $200 more a year than most seniors spend on all other health care services and supplies combined.[11] In short, many of those living on a fixed income or at the threshold of poverty cannot afford to pay the premiums and out-of-pocket expenses now required to obtain and maintain pharmacy coverage.

At this juncture, there is no data available that evaluates the enrollment trends of Medicare beneficiaries by population (aged v. disabled) or by income. As a result, it is not possible to state with any degree of certainty how many members of the target population are enrolled in health plans that provide prescription medication coverage. The State's best estimate, based on data collected through RIPAE for the purposes of coordinating benefits, is that approximately 30% of the target population has at least a limited pharmacy benefit. Though monthly premiums vary by plan, the average annual cost for a Medi-gap plan with a generous pharmacy benefit (i.e., open-formulary, no benefit cap, minimal co-pays) is $3,100; for a Medicare + Choice plan

providing broad Rx coverage, the annual premium cost is $1,525. With the exception of public employee retiree health plans, the average cost of employer-based coverage falls in the mid-range between the Medicare + Choice and Medi-gap plans with the most comprehensive prescription benefit packages.[12] In sum, with a median annual income of $13,000, paying the premiums for even the least expensive of these plans, along with annual out-of-pocket prescription costs of close to $900, may have put other forms of coverage out of the financial reach for the 70% of the target population expected to be without a pharmacy benefit.

DEMONSTRATION RESEARCH DESIGN AND HYPOTHESES

I. Purpose

The State's primary purpose in pursuing a Pharmacy Plus Section 1115 Medicaid Waiver is to provide both the elderly and individuals with disabilities the prescription medications they need to maintain their health and independence. Rhode Island, like many other states, is now in the midst of fiscal crisis that threatens the continued viability of several of its most effective human service programs, including Medicaid. Given these fiscal constraints, expanding the State's existing prescription programs is not a viable option at this time. Through a Pharmacy Plus Waiver, the State will be able to leverage existing funds to gain the resources required to provide a comprehensive prescription benefit to low-income seniors and, at least initially, a limited number of its most vulnerable, seriously ill residents.

It is important to note that current budget limitations prevent the State from including in the waiver many of the individuals living with disabilities who would otherwise meet the eligibility criteria for RIx +coverage. Once the necessary State resources become available, the waiver, if approved, will be amended accordingly.

Although the primary purpose for seeking the waiver is to assist Rhode Islanders in need, increasing access to prescription medications has the potential to yield more far-reaching benefits. Specifically, the State stands to gain significantly if the improvements in health status associated with greater use of prescription medications result in a decrease in the utilization of more expensive forms of health care. As recently as five years ago, there was not sufficient empirical evidence to support the existence of a direct linkage between access to affordable prescription coverage and consumption of other costly health care services. Since then, the influx of several new classes of highly efficacious, and pricey, therapeutic drugs into the health care market-place has resulted in marked improvements in general health status, particularly for the elderly with chronic conditions. Consequently, there is now a compelling body of research showing the linkage between Rx coverage, prescription medication utilization, and the need for and use of other forms of care. [13]

For example, one recent study reported that seniors with Rx coverage not only fill more prescriptions than those without it (18 v. 27 on average annually), but both self-report their health as better and use fewer other costly services to prove it – e.g., lower hospitalization and nursing home admissions rates. The study also found that low-income seniors with continuous pharmacy coverage had much lower out-of-pocket health care expenses than those without a Rx benefit and, as such, were more likely to have the financial resources required to remain in the community when their health began to decline. [14]

Recent trends in heath care expenditures in state Medicaid programs, Rhode Island's included, suggest use of prescription medications can yield cost savings as well. Some states have reported that elderly Medicare beneficiaries with Rx coverage spend-down for Medicaid eligibility as medically needy far less often and that, when they do become eligible, most require fewer days of expensive institutional care. Moreover, states that have limited Medicaid prescription benefits as a cost-savings measure have found that spending related to hospitalization and emergency room visits increased at much faster pace

than in the period before the cuts were made.[15] Current utilization patterns in the RI Medicaid program tend to support these findings. The available data indicate that per case per month (PCPM) expenditures for prescription drugs utilized by the State's aged Medicaid population (income up to 100% FPL) have gone up by about 8% each year since SFY 1999. Over this same period, PCPM cost for institutional level care (nursing homes, hospitals, home and community-based services) have declined by a total of 10%. Although there are several other factors known to have contributed to these trends (e.g., a slight drop in the size of the eligible population), these data provide reasonably reliable evidence that a linkage exists between prescription medication access and the utilization of institutional levels of care.

II. Demonstration Hypothesis and Research Design

Given the findings note above, the State expects the RIx + waiver, if approved, to broaden access to Rx coverage, improve health status and decrease reliance on and utilization of more expensive forms of care. These are, in some sense, the goals that the Pharmacy Plus waiver program was designed to achieve.

However, there are certain financial risks attendant with expanding access to and utilization of services through the **RIx +** waiver. Of specific concern is the high cost of many of the most efficacious prescription medications now on the market and the possibility that expanding access to coverage will result in inefficient and/or inappropriate patterns of utilization. Accordingly, the State is interested in demonstrating the following:

1. Effective pharmacy benefits management, including a disease-centered prior authorization system, will limit growth in PCPM annual pharmacy expenditures, improve health status, and promote efficient and responsible utilization of prescription medications by members of the target population enrolled in the waiver; and

2. Use of cost-sharing system that provides incentives for use of generic medications will decrease reliance on expensive brand name drugs and, in doing so, will assist in containing the costs of higher prescription drug utilization.

The data used to test these two hypotheses is available through the State's Medicaid Management Information System (MMIS).

Pharmacy Benefits Management: Hypotheses #1

Can effective pharmacy benefits management, including a disease-centered prior authorization system, both improve health and contain the costs of higher of prescription medication utilization?.

At present, the average per member cost of prescriptions for the aged and disabled Medicaid population is about $1,475 per year, including those residing in the community as well as institutions. According to one source, the average cost of prescriptions for Medicare + Choice enrollees living in the community is estimated at $1,260 per annum.[16] Given the high Rx utilization rate of Medicaid recipients (approximately 37 per year) in comparison to that of Medicare beneficiaries (reportedly 28 per year), the State Medicaid program appears to be utilizing resources more effectively than Medicare + Choice plans, even though the latter often include a variety of cost-saving mechanisms (e.g., closed formularies, deductibles and co-insurance). The efficiency of the Rhode Island Medicaid program is due in part to advantageous drug rebates, but also to the effectiveness of its pharmacy benefits management program and prior authorization system.

As the State plans to incorporate both of these mechanisms into the **RIx+** waiver system, PCPM expenditures for the target populations should be comparable. Accordingly, the State will evaluate data on Rx utilization and expenditures for **RIx +** enrollees relative to the Medicaid population of aged and disabled as whole to determine whether similar efficiencies occur. Data to be included in the evaluation include: PCPM Rx costs, prescriptions filled per annum, percent subject to prior authorization system protocols and average increase in utilization and expenditures for members of the target population over-time.

Generic Drug Utilization: Hypotheses #2

Will the lower co-payments for generic prescription medications included in the waiver's cost-sharing scheme decrease enrollee utilization of more expensive name brand drugs over-time?

Another factor that has contributed to the comparatively low cost of Rx coverage in the State's Medicaid program is the requirement that prescriptions be filled with generic drugs whenever available. Although many of the newer and more efficacious medications now on the market are single source, name brands, a substantial number of the prescription drugs the elderly use most often are available in generic form.

The State has found that the reluctance of recipients to accept generic substitutes is one of the chief reasons utilization of multi-source medications remains high. Several studies have reported that health plan enrollee concerns about generic drugs can be readily over-come if education about their effectiveness is provided at the point-of service. Similarly, commercial plans have found that enrollee reservations about generic drugs become a less important factor when co-pays for well-known name brand alternatives are set substantially higher.[17]

In order to maximize limited waiver resources, the State plans to use both education and lower co-payments to encourage enrollees to utilize more generic prescription medications. The potential savings are significant. It is not uncommon for a name brand medication to cost three or more times as much as a generic alternative.[18] As one of the central goals of the waiver is to promote responsible utilization, the State will be tracking the number of prescriptions filled with generic substitutes on a continual basis. In addition to focusing on actual overall prescription expenditures, the State will assess the probable change in waiver costs if prescriptions were filled with generic medications in every instance in which they were available. The State intends, as well, to examine the cumulative impact of generic drug and pharmacy benefits management on utilization and average annual PCPM prescription costs.

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[1] Number of total eligible Rhode Islanders based on income and age data from the 2000 census as reported by the Rhode Island State Planning Commission.

[2] According to the U.S. Center of Population Studies (CPS), Rhode Island's uninsured rate was the lowest in the nation in 2000 and 2001 at about 6%; in addition, the State ranked first in the nation in percent of children with health coverage – 98% with coverage and only 2% uninsured. Data reported in the Rhode Island Governor's Advisory Council on Health , *Annual Report 2001*, (www.gov.state.ri.us/GAC_hlth/).

[3] Based on an analysis of the services provided to recipients, both the AARP and Urban Institute reported that the State's Medicaid program was the eighth most generous in the U.S. in 2000 and 2001.

[4] In 1997, there were 73,000 children and families covered by Medicaid; by end of the 2001 calendar year, the number of Medicaid recipients in this population had reached 116,000, an increase of nearly 59% in just five years.

[5] Eligibility was extended up to 100% of the FPL in SFY 2001. Most other expansions were the result of Home and Community-Based Services waivers and have had only a modest impact on the total number of eligible recipients in the population.

[6] Data Source for RI Medicaid unless otherwise indicated is RI Department of Human Services, Division of Health Care Quality, Financing and Purchasing, Office of Contracting and Payments.

[7] The per capita per month (PCPM) cost of institutional level care for both groups far exceeded that for all other providers combined (includes physicians and other professionals, pharmacy and behavioral health). For the aged, nursing home PCPM costs were the highest whereas for persons with disabilities, PCPM expenditures for home and community based services took the top spot.

[8] Source: Data derived from Medicare Enrollment Files, Centers for Medicare & Medicaid Services (CMS) located at http://cms.hhs.gov/statistics/enrollment/; State Health Facts Online, Henry J. Kaiser Family Foundation located at http://statehealthfacts.kff.org; and RI Department of Human Services, Division of Health Care Financing and Purchasing.

[9] Although enrollment in Medicare + Choice and Medi-gap plans has decline by 20% since 1999, Rhode Island has not experienced the mass exodus of plans from the market that has occurred in other states.

[10]Source: Congressional Research Service, *Regional Variations in Medicare Beneficiary Coverage.* Report prepared for the Select Committee on Health, July 2002. Note: As the data for this report were compiled from a variety of different sources and then re-calculated to based on national figures, the findings are best viewed as a reflection of enrollment trends rather than actual enrollment

[11] See: Congressional Budget Office (CBO). *Projections of Medicare and Prescription Drug Spending*, Statement of Daniel L. Crippen, CBO Director, before the Committee on Finance, US Senate (3/7/02) located at http://www.cbo.gov/showdoc.cfm?index=3304&sequence=0 and Gross, David, *Medicare Beneficiaries and Prescription Drugs: Costs and Coverage*, AARP Public Policy Institute, Data Digest #77 (09/02).

[12] Estimates based on insurer filings provided by the Rhode Island Department of Business Regulation, Insurance Division.

[13] For a review of these studies and findings see: Kaiser Family Foundation, *Medicare and Prescription Drug Coverage: A Chartpack*, (June 12, 2002). (www.kff.org/content/2002/6048/); Merlis, Mark, *Explaining the Growth in Prescription Drug Spending: A review of recent studies* (Report prepared for the U.S. Department of Health and Human Services, August 2000). (www.aspe.hhs.gov); National Conference of State Legislatures, *Medicaid Prescription Drug Laws and Strategies for 2001-2002.* (www.ncsl.org/program/health/medicaidrx.htm), (updated 9/02); and Gross, D. and Brangan, N., *Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections*, PPI Publication IB#41 (AARP, December 1999)

[14]See Gross, D. AARP (9/02).

[15] See Crippen, D. CBO Testimony (3/02)

[16] Ibid.

[17] Source: Verispan Scott-Levin Source ™, Prescription Audit: Special Data Request, 2001;

[18] See: National Conference of State Legislatures, *Medicaid Prescription Drug Laws and Strategies for 2001-2002.* (www.ncsl.org/program/health/medicaidrx.htm), (updated 9/02).